TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Susan Van De Water, M.D.

Respondent Name
Bitco National Insurance Company

MFDR Tracking Number
M4-16-3392-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION/PARTIAL PAY"

Amount in Dispute: $165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOB(s) and the reduction rationale(s) stated therin."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2016	Designated Doctor Examination	$150.00	$150.00
February 3, 2016	Work Status Report	$15.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 234 – This procedure is not paid separately.
   - ORC – See Additional Information – "MMI/IR/DRE (1 AREA)"
   - P12 – Workers' Compensation State Fee Schedule Adj
   - ORC – See Additional Information – "ADDITIONAL FOR ROM (1 AREA)"

Issues

1. What are the services considered for this dispute?
2. Is the insurance carrier's denial of payment for procedure code 99080-73 supported?
3. What is the maximum allowable reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor included the following procedures codes and amounts on the Medical Fee Dispute Resolution Request (DWC060):

   - 99456-W5-WP – $150.00
   - 99456-W8-RE – $0.00
   - 99080-73 – $15.00

   Because the requestor is seeking $0.00 for procedure code 99456-W8-RE, this code will not be considered for the dispute in question.

2. The insurance carrier denied disputed procedure code 99080-73 with claim adjustment reason code 234 – "This procedure is not paid separately." Per 28 Texas Administrative Code §134.204(l),

   > The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title (relating to Work Status Reports).

   Therefore, the filing of the DWC-073 is not separately payable when provided in conjunction with a Designated Doctor Examination performed according to 28 Texas Administrative Code §134.204(i). The insurance carrier's denial for this code is supported.

3. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   28 Texas Administrative Code §134.204(j)(4) states:

   (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
   - (i) Musculoskeletal body areas are defined as follows:
     - (I) spine and pelvis;
     - (II) upper extremities and hands; and,
     - (III) lower extremities (including feet).
   - (ii) The MAR for musculoskeletal body areas shall be as follows.
     - (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
     - (II) If full physical evaluation, with range of motion, is performed:
       - (-a-) $300 for the first musculoskeletal body area; and
       - (-b-) $150 for each additional musculoskeletal body area.

   (D) …
   - (i) Non-musculoskeletal body areas are defined as follows:
     - (I) body systems;
     - (II) body structures (including skin); and,
     - (III) mental and behavioral disorders.
   - (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides…
   - (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

   Review of the submitted documentation supports that the requestor performed an impairment rating examination with range of motion for the lumbar spine and provided an impairment rating for the groin, a non-musculoskeletal body area. Therefore, the MAR for these examinations is $450.00.

4. The total MAR for the disputed services is $800.00. The insurance carrier paid $650.00. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	August 16, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.